PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

08127

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Brinkelow md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Brinklow
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rosie E. Bacon

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 1. 1877

8. AGE: Years 68 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Walker
13. Birthplace Howard Co. Md

MOTHER
14. Maiden name
15. Birthplace

16. Informant Samuel T. Bacon Son
Address Brinklow. md

17. Buried (Burial, cremation, or removal. Which?) Date thereof aug 14 1945 (month) (day) (year)
Cemetery or crematory Sandy Springs
Location Sandy Spring, Md

18. Funeral director Robert L. Snowden
Address 246. N. Washington St. Rockville

19. Aug 13 1945 (Date rec'd by registrar) Gertrude B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH aug 12 1945, at 4.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug 9 1945, to aug 12 1945
and that I last saw her alive on aug 11 1945

Immediate cause of death	DURATION
Chronic nephritis	18 mo
Due to	
Due to Chronic Myocarditis	18 mo.
Other conditions Malignant Hypertension	12 mo.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Calvin B. LeCompte M.D.
M. D. or other
Address Wheaton Md Date signed 8/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

08128

CERTIFICATE OF DEATH

Reg. Dist. No. 214

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, institution, or street address where death occurred: 302 Ellsworth Drive.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Silver Spring.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 302 Ellsworth Drive

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME Minnie Louise Beyer Beyan

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Beyan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 24, 1870

8. AGE: Years	Months	Days	If less than one day
75	0	5	..... hrs. ..... min.

9. Birthplace: Brooklyn N.Y.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Daniel Bedell

13. Birthplace: — New Jersey.

MOTHER — 14. Maiden name: Martha Coultas

15. Birthplace: — England.

16. Informant: Mrs C.J. Baker

Address: 302 Ellsworth Drive Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug Sept-1-45. (month) (day) (year)

Cemetery or crematory: Evergreen -

Location: Long Island N.Y.

18. Funeral director: Warner & Pumphrey

Address: 8 & 31 Ga Ave Silver Spring Md

19. Aug 30 1945 (Date rec'd by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1945 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to Aug 29th 1945

and that I last saw h.. alive on Aug 28th 1945

Immediate cause of death	DURATION
Hypertension Pneumonia	1 day
Due to	
Due to	
Other conditions: Hypertension Heart disease. (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Marion Burnhead M.D. M. D. or other

Address: 9601 Dutton Place Silver Spring Md. Date signed 8/29/45

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

08129

CERTIFICATE OF DEATH

★ Reg. Diat. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: (Rural) Rockville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months-4 days
Hospital, institution, or street address where death occurred:
Waverley Sanitarium
How long in hospital or institution? Six months-4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. Columbia County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3801-T St. N.W.
(If rural, give LOCATION)
2(a) If veteran, name war: unknown

3. (a) FULL NAME: Wesley Graham Bishop

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Annie Frances Bishop — Bishop
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): Aug. 7-1852

8. AGE: Years	Months	Days	If less than one day
92	11	27	— hrs. — min.

9. Birthplace: Rural Maryland
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:

FATHER
12. Name: Elias Bishop
13. Birthplace: Maryland

MOTHER
14. Maiden name: Talitha Royston
15. Birthplace: Maryland

16. Informant: Randolph Bishop
Address: 5555-Bradley Blvd. Bethesda, Md.
17. Burial Bethesda, Aug. 6/45
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Rosemont
Location: Baltimore-Md.
18. Funeral director: Joseph Darrin Sons
Address: 125-Pa. Ave. N.W.
19. 8/4 19 45 Wm E Jolley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 19 45 at 7.00 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 21 19 45 to Aug. 4- 19 45
and that I last saw him alive on Aug. 3 Rd. 19 45

Immediate cause of death	DURATION
Chronic myocardial insufficiency.	2 years
Due to age.	
Due to Arterio-sclerosis	10 years
Other conditions Chronic interstitial nephritis.	5 years

(Include pregnancy within 8 months of death)

Major findings of operations: /
Date of op. /
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of /
Where did injury occur? (City or town) (County) (State) /
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wheeler O. Stull M.D. or other
Address: Bethesda Md. Date signed: 8-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74(a)

CERTIFICATE OF DEATH

08130

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Cabin John
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred: #5-Webb Rd, Cabin John Gardens
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Cabin John
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5-Webb Rd. Cabin John Gardens
(If rural, give LOCATION)
2.(a) If veteran, name war: Cabin John, Md.

3.(a) FULL NAME: Samuel Edwin Boyce

3.(b) Social Security Number: 577-10-9569.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Ethel Gertrude Boyce
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 14, 1880.

8. AGE:

Years	Months	Days	If less than one day
65	1	4	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Bricklayer
11. Industry or business: House Construction

FATHER
12. Name: Samuel Edwin Boyce, Sr.
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Adelaide Prather
15. Birthplace: Baltimore, Md.

16. Informant: Ethel Gertrude Boyce
Address: #5-Webb Rd, Cabin John, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug. 22 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Md
18. Funeral director: Deal Funeral Home
Address: 4812-Galen N.W. Wash. D.C.

19. 8/18 1945 (Date rec'd by registrar) Mrs E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1945, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19th 1945, to August 18 1945
and that I last saw him alive on August 18 1945

Immediate cause of death	DURATION
Lymphatic Leukemia (Lymphocytic Leukemia)	10 months
Due to	
Due to	
Other conditions: Chronic interstitial nephritis (Include pregnancy within 3 months of death)	Unknown

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wheeler D. Huff M.D. or other
Address: Bethesda, Md. Date signed: Aug. 18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08131

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-C) X

CERTIFICATE OF DEATH

★ Reg. Dist. No. 799 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Rose Byers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John H. Byers

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	20	hrs. min.

9. Birthplace Loudoun Co., Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Henry Rogers

FATHER 13. Birthplace Loudoun Co. Virginia

MOTHER 14. Maiden name Emma Beach

MOTHER 15. Birthplace Virginia

16. Informant

Address

17. ~~Burial~~ (Burial, cremation, or removal. Which?) Date thereof Aug. 23 1945 (month) (day) (year)

Cemetery or crematory Glenwood.

Location Washington D. C.

18. Funeral director W. W. Chamber Co.

Address 3072 - Mt. Pl. N. W.

19. 8/23/45 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1945, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 - 1945 to Aug. 23 1945 and that I last saw her alive on August 21 - 1945

Immediate cause of death	DURATION
Carcinoma of the uterus.	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation - No surgery done Date of op.

Autopsy results Carcinoma of the Uterus.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wheeler O. Huff M. D. or other

Address Bethesda, Md. Date signed 8-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on

08132

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

FILM No. G 97 AUG 31 1945

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery Inst BETHESDA
City or town
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 5-5-20 Greenway Drive
Stay in hospital or inst. (yrs., or mos., or days) X
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town 5-5-20 Greenway Dr. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Bethesda
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME JOSEPH STEELE CALHOUN

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret
6(c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.): Nov. 4 1898
8. AGE: Years 46 Months 7 Days 6 If less than one day ____ hrs. ____ min.
9. Birthplace: Philadelphia Pa (Town, county, and state)
10. Usual occupation: Engineer Dept
11. Industry or business: U.S. Government
FATHER 12. Name: Joseph Calhoun
13. Birthplace: Pa
MOTHER 14. Maiden name: unknown
15. Birthplace: "
16. Informant: F. C. Cooper
Address: 3802 Tilton Rd. NW.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/9/45 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director: W. W. Chamberlain Co.
Address: 3072 M St NW
19. 8/9 19 45 Wm E Jobes (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 45, at 4:P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 21 19 45, to Aug. 9 19 45, and that I last saw him alive on July 12 19 45.

	DURATION
Immediate cause of death: Coronary Artery Occlusion	Hrs.
Due to: Old Coronary Artery Disease	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John R. Ewan, M.D. M. D. or other
Address 1801 Eye St. N.W. Date signed 8-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08133

Reg. Dist. No. 213-

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Montgomery
City or town: Potomac, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Potomac, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles C Cloud

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: House man
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18, 1945 (month) (day) (year)
Cemetery or crematory Lincoln Memorial Cem.
Location Washington, D. C.

18. Funeral director Robert L. Snyder
Address 246 N. Wash. St Rockville Md

19. 8/19/45 (Date rec'd by registrar) 19 Josephine D. Foster M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1945 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to Aug. 19 45
and that I last saw h alive on 19

	DURATION
Immediate cause of death: Bullet thru skull (Suicide)	dead
Due to:	instantly
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 8-14-45
Where did injury occur? Rockville R-1 Montg. Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Injured at work?

23. SIGNATURE Frank J. Bronhart M.D.
Dep. Med Exam M. D. or other
Address Gaithersburg Md Date signed 8-14-45

ORIGINAL COPY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08134

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Col. County:

City or town: Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2905 13th St. N.W. Wash. D.C. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Coleman, Marvin Sherwood

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 9, 1929

8. AGE: Years	Months	Days	If less than one day
16	6	21	hrs. min.

9. Birthplace: Roanoke, Va. (Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER 12. Name: Mr. Clarence Coleman

FATHER 13. Birthplace: Roanoke, Va.

MOTHER 14. Maiden name: Miss Ruth Broughman

MOTHER 15. Birthplace: Iron Gate, Va.

16. Informant: Washington Sanitarium + Hosp.

Address: Takoma Park, Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 1, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Roanoke Va.

18. Funeral director: H. H. Hines Co

Address: 2901-14th St. N.W.

19. Aug 31 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 30 19 45, at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam Case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
(a) Lobar pneumonia (hypostatic)	2 days
Due to, (b) Bullet wound thru left lung and heart (accidental)	8-27-45
Due to, (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 8-27-45

Where did injury occur? Silver Spring Montg. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): woods

Means of injury: gun shot Injured at work? no

23. SIGNATURE: Frank J. Bruchart M.D. M. D. or other

Address: Silver Spring, Md. Date signed: 8-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9403)

CERTIFICATE OF DEATH

08135

Reg. Dist. No. 223-

1. PLACE OF DEATH

County: Monty

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 11 Philadelphia ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME George Donnelly Curran

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Clare Curran

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Jan 16 1880

8. AGE: Years	Months	Days	If less than one day
✓ 65	7	9	...hrs. ...min.

9. Birthplace: Lincoln, Neb. (Town, county, and state)

10. Usual occupation: salesman

11. Industry or business: engineer

FATHER — 12. Name: John W. Curran

FATHER — 13. Birthplace: Wis.

MOTHER — 14. Maiden name: Clara Moody

MOTHER — 15. Birthplace: N.Y.

16. Informant: Mrs. Clare Curran

Address: 11 Plaza ave. Takoma Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28 1945 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington D.C.

18. Funeral director: Arthur Sellers

Address: 5th & Carroll St. N.W. Takoma Park D.C.

19. 8 28 45 19... (Date rec'd by registrar) J. Wm Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 19 45 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def. Med. Exam 19... to ...19... and that I last saw h... alive on Aug 19...

	DURATION
Immediate cause of death	died
Coronary occlusion	suddenly
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhaut M.D. M. D. or other

Def. Med. Exam.

Address: Gaithersburg Md. Date signed: 8-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08136

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Diat. No. 212

1. PLACE OF DEATH:
County: Montgomery
City or town: Comus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty.
City or town: Comus
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SARAH LOUISA DILLOW

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas W. Dillow
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): June 26 1861

8. AGE:

Years	Months	Days	If less than one day
84	1	24	....hrs. ....min.

9. Birthplace: Clark Co. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Wm. B. Sowers
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Betty Grubbs
MOTHER 15. Birthplace: Virginia
16. Informant: Thomas W. Dillow
Address: Comus, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-24-45 (month) (day) (year)
Cemetery or crematory: S.D.A. Cem.
Location: Comus, Md.
18. Funeral director: Wm. B. Hilton
Address: Barnesville, Md.
19. Aug. 23 1945 (Date rec'd by registrar) Mrs. C.C. Hilton By Mrs. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1945, at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15- 1945, to Aug. 22- 1945, and that I last saw her alive on August 22 1945

Immediate cause of death	DURATION
Hypostatic pneumonia	3 days.
Due to: Arteriosclerosis	15 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. D. White, Md.
M. D. or other
Address: Barnesville, Md. Date signed 8/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

68137

★ Reg. Dist. No. 26

1. PLACE OF DEATH:
County Monty
City or town Dorbeck Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred: Manor Club Park
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Monty.
City or town Dorbeck Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Manor Club Park
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Dorothy De Vean Dulin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Capt. Robert M. Dulin 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1909

8. AGE: Years	Months	Days	If less than one day
36			hrs. min.

9. Birthplace New Rochelle N.Y. (Town, county, and state)
10. Usual occupation housewife
11. Industry or business
FATHER 12. Name Joseph F. De Vean
13. Birthplace New York
MOTHER 14. Maiden name Ida H. Berlet
15. Birthplace New York
16. Informant Donald E. De Vean
Address Jones Bridge Rd.
17. Burial, cremation, or removal. Which? Burial Date thereof 8/23/45 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cem.
Location Maryland
18. Funeral director Wm Reuben Humphrey
Address 7557 Wis. Ave. Bethesda
19. 8/23 1945 Wm E. Jones Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1945 at 4:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. Med. Exam 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death Intra cranial hemorrhage	Imp
due to fracture of skull	dead
Due to (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 8-20-45
Where did injury occur? Rockville R.F.D. Monty Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Fell down steps Injured at work? no

23. SIGNATURE Frank J. Groschart M.D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg Md Date signed 8-20-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

★ 08138

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Monty.

City or town Silver Spring R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1941 Columbia Rd N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Anna Marie Eggenhoff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1874

8. AGE:

Years	Months	Days	If less than one day
71	0	11	hrs. min.

9. Birthplace Mariposa Cal. (Town, county, and state)

10. Usual occupation Christian Science practitioner

11. Industry or business

FATHER

12. Name David Eggenhoff

13. Birthplace Holland

MOTHER

14. Maiden name Maria Anna Holtzschuiter

15. Birthplace Germany

16. Informant Mrs. Anna L. Ehlers

Address Silver Spring R.F.D. Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Aug 22 1945 (month) (day) (year)

Cemetery or crematory Cremation at Lees Sons

Location Washington, D.C.

18. Funeral director J. A. Williams Lee's Sons & Co.

Address 300-4 St. N.E. Washington D.C.

19. Aug 22 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1945, at 9:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 Med. Exam. 19 to case 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Diabetic Coma	1½ days
Due to Diabetic Mellitus	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bronhart M.D. Dep. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 8-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

08139

★ Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Bethesda - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 20 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montg.

City or town: Cabin John Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Halpine St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mr. John Joseph Fields

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife: Myrtle Irene Fields

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): March 12 - 1889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	5	—	—	

9. Birthplace: Baltimore - Md. (Town, county, and state)

10. Usual occupation: U.S. Government

11. Industry or business

FATHER — 12. Name: Mr. ? Fields

13. Birthplace

MOTHER — 14. Maiden name: Katherine Elizabeth ?

15. Birthplace ?

16. Informant: Mrs Lillian Stephens

Address: daughter

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/16/45 (month) (day) (year)

Cemetery or crematory: Potomac Cem.

Location: Potomac, Md.

18. Funeral director: Wm Reuben Tremblay

Address: 7557 Wis. Ave. Bethesda

19. 8/15 1945 Mr E Jobe Md. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 12 1945, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1, 1944 to Aug 12, 1945 and that I last saw him alive on Aug 12 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 years
Due to: Chr. arteriosclerosis	5 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. G. Bamford M.D. M. D. or other

Address: Bethesda, Md. Date signed 8/14/45

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. O. E. Marland 1216-16 St. NW

Reg. No. G 98 SEP 18 1945

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
8 E. Underwood Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 East Underwood St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JAMES BLAINE FITZGERALD

3.(b) Social Security Number 579-01-2605

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mary Elizabeth Fitzgerald
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1895 1892

8. AGE: Years	Months	Days	If less than one day
53	0	26	..... hrs. ..... min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual occupation Lawyer
11. Industry or business

MOTHER FATHER
12. Name Edwin Fitzgerald
13. Birthplace Ireland

MOTHER
14. Maiden name Margaret Fagan
15. Birthplace Ireland

16. Informant Mary Elizabeth Fitzgerald
Address 8 E. Underwood St., Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1945 (month) (day) (year)
Cemetery or crematory Arlington National Cemetery
Location Fort Myer, Va.

18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.

19. 8/31 19 45 (Date rec'd by registrar) Wm E Fowler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 19 45, at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 19 44 to Aug 29 19 44
and that I last saw h.. alive on Aug 28 19 44.

Immediate cause of death	DURATION
Carcinoma right Kidney	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Large malignant kidney
Date of op. Sept 13 1944
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE O E Marland M.D. M. D. or other
Address 1216 16th St. NW Date signed Aug 30 44
Washington DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of approximate age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

Reg. No. G 98 SEP 18 1945

08141

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Milwaukee, Wis.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GEISEL, Rose

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
approx. 67			hrs. min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: unknown

13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: daughter: Magdalen R. Geisel, Ylc

Address: Navy #128, Wave Barracks, c/o FPO San F Calif.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 8-15-45 (month) (day) (year)

Cemetery or crematory:

Location: Milwaukee, Wis.

18. Funeral director: Deal Funeral Home

Address:

19. Aug 14 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13th 1945 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13th 1945, to Aug 13 1945 and that I last saw him alive on Aug 13 1945

Immediate cause of death	DURATION
Coronary occlusion	2 days
Due to: Arteriosclerosis	
Other conditions: Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Lamb M.D. or other

Address: U.S. Naval Hospital Bethesda Date signed: Aug 14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8/1/4

08142

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 2/2

1. PLACE OF DEATH:
County: Montgomery Co
City or town: Martinsburg Rural Dickerson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Martinsburg Rural Dickerson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Isaac Albert Gibbs

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 26 - 1876

8. AGE:

Years	Months	Days	If less than one day
69	5	12	..... hrs. ..... min.

9. Birthplace: Montgomery Co, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm
FATHER 12. Name: Samuel Gibbs
13. Birthplace: Montgomery Co., Md
MOTHER 14. Maiden name: Ellen Dorsey
15. Birthplace: Montgomery Co., Md.
16. Informant: John Thompson
Address: Dickerson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/10/45 (month) (day) (year)
Cemetery or crematory: Martinsburg
Location: Near Dickerson
16. Funeral director: Clarence H. Davis
Address: Poolesville Md
19. Aug. 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 7 - 1945 - at 9:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 - 1943, to Aug. 6 - 1945 - and that I last saw him alive on Aug. 6 - 1945 -

Immediate cause of death	DURATION
Organic heart disease	5 yrs +
Due to: arterio-sclerosis	5 yrs +
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Byron S. White, Md.
M. D. or other
Address: Poolesville, Md. Date signed 8/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462) K

08143

CERTIFICATE OF DEATH ★ Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 2 hrs - 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Glen Echo Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wapakoneta Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Bernard Gorman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary Ann Whelan (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 1, 1863

8. AGE: Years 82 | Months 7 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Pontefrax, Yorkshire, England (Town, county, and state)

10. Usual occupation Book Keeper

11. Industry or business

FATHER 12. Name John Gorman
13. Birthplace England

MOTHER 14. Maiden name Julia Mahar
15. Birthplace County Mayo, Ireland

16. Informant Nora Gorman, daughter
Address Washington 16, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 10, 1945 (month) (day) (year)
Cemetery or crematory Ft Lincoln
Location
18. Funeral director W. W. Chambers Co
Address 3071 - M St N.W. Wash.

19. 8/8 (Date rec'd by registrar) 19 45 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 19 45 at 1:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 42 to August 5 19 45
and that I last saw h.i.m alive on August 7 19 45

Immediate cause of death	DURATION
Carcinoma of ascending colon	1 year
Due to	
Due to	
Other conditions Secondary anemia	6 months

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Carcinoma of ascending colon.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Bruce T. Benjamin M.D.
M. D. or other
Address Bethesda, 14, Md. Date signed 8/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8144

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Six days

Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? Six days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County PRINCE GEORGES

City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8527 - 58th St
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Gupton, Lucy B

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Ewing Gupton

6.(c) If alive, give age ~~59~~ years

7. Birth date of deceased (mo., day, yr.) Aug. 13 - 1886

8. AGE: Years	Months	Days	If less than one day
59			....hrs. ....min.

9. Birthplace Belleville Ill.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

18. Informant Washington San. & Hosp. Records

Address

17. Removal Date thereof Aug 31. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hyattsville Md

Location

18. Funeral director J Gascho sons

Address Hyattsville Md.

19. Aug 31 1945 J. R. Dudley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1945, at 8 25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Aug 31 1945 and that I last saw ~~her~~ alive on Aug 30 1945

Immediate cause of death	DURATION
Ch. myocarditis	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Swan Hup M. D. or other

Address Hyattsville. Md Date signed 8-31-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

08145 Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:
on street 7929 Ga. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 616 Eye St. N. E. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME ARCHER L. HARDAWAY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Irene L Hardaway 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1-7-1891?

8. AGE: Years	Months	Days	If less than one day
54			hrs. min.

8. Birthplace: Va (Town, county, and state)

10. Usual occupation: Structural Steel worker

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace: Va

MOTHER 14. Maiden name: Wade

15. Birthplace: Va

16. Informant: Mrs Irene L Hardaway

Address: 616 - 1st N E

17. Burial (Burial, cremation, or removal, Which?) Date thereof 8-25-45 (month) (day) (year)

Cemetery or crematory: Arlington Natl Cem

Location: Arl Va

18. Funeral director: Huntemann Funeral Home

Address: 5732 Ga Ave N W

19. Aug 22 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1945, at 2:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep Med Exam 19 Exam to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Electrocution (accidental)	killed instantly
Due to contact with high tension wires.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 8-22-45

Where did injury occur? Silver Spring (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): immaterial

Means of injury: high tension wire Injured at work? yes

23. SIGNATURE: Frank J. Brosnahan M.D.
Dep Med Exam M. D. or other

Address: Gaithersburg Md Date signed 8-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742) K

CERTIFICATE OF DEATH

8146

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one day, 1 hour

Hospital, institution, or street address where death occurred:

The Washington Sanitarium and Hospital

How long in hospital or institution? one day, 1 hour.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 Waterford Road

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mary Kate Hayes

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 7, 1938

8. AGE:

Years	Months	Days	If less than one day
7	5	4	... hrs. ... min.

9. Birthplace Yonkers New York

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name Raymond J. Hayes

13. Birthplace New York State

MOTHER

14. Maiden name Veronica Murphy - Hayes

15. Birthplace Yonkers New York.

16. Informant Records of the Washington Sanitarium and Hospital

Address Dr. J. Meyers 318 Waterford Drive, Silver Springs, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 13, 1945 (month) (day) (year)

Cemetery ~~or crematory~~ Mt. Olivet Cemetery

Location Washington, D.C.

18. Funeral director Waxnex E. Pumphrey

Address Silver Spring, Md.

19. Aug 12 1945 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1945 at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1944 to date 1945

and that I last saw her alive on 8-10-45 1945

Immediate cause of death	DURATION
Profuse Abdominal Hemorrhage	10 min.
Due to Ruptured Liver, secondary to the leukemia	10 min.
Due to Leukemia CWR	5 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE C. M. Hamner M.D. M. D. or other

Address 8632 Colesville Rd Silver Spring, Md. Date signed 8-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 11814 2273-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
703 Kennebec Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery.
City or town Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 703 Kennebec Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM HAZEL

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	WIDOWED

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) NOV. 25, 1852.

8. AGE: Years	Months	Days	If less than one day
92	8	24	..... hrs. ..... min.

9. Birthplace MONROE COUNTY, INDIANA (Town, county, and state)
10. Usual occupation RETIRED - FARMER.
11. Industry or business INDIANA.

FATHER
12. Name JACKSON HAZEL.
13. Birthplace INDIANA.

MOTHER
14. Maiden name SARAH FLOOD.
15. Birthplace INDIANA.

16. Informant MAJOR H.C. HAZEL.
Address 703 KENNEBEC AVE, TAKOMA PARK, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof AUG 22, 1945. (month) (day) (year)
Cemetery or crematory
Location HARRODSBURG, INDIANA -

18. Funeral director Arthur Stalkers
Address 24 Carroll St. N.W. Takoma Park D.C.

19. 8/19/45 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 19, 1945 at 12 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchart M.D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg, Md. Date signed 8-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

[redacted] 223

Reg. Dist. No.

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: Arlington

City or town: Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3613 So. 9th Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. George Hoffman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Edith Hoffman 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 14, 1885

8. AGE: Years	Months	Days	If less than one day
60	4	6	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace

MOTHER 14. Maiden name

MOTHER 15. Birthplace

16. Informant: Records, Wash. Sani. Hosp.

Address: Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 20 - 45 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director: S. A. Hines Co.

Address: 2901-14th St. N.W. Wash. D.C.

19. Aug 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20 1945 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to Aug 20 1945 and that I last saw him alive on Aug. 19 1945

Immediate cause of death	DURATION
Acute Congestive Heart Failure	1 da
Due to: Tachycardia	5 da.
Due to: Acute Pneumothorax with bilateral Hydropneumothorax	2 yrs + 5 yrs +
Other conditions: Neuro Syphilis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Takoma Park Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8149

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mons & 27 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 mons & 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.Y. County:

City or town: Freeport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Gordon Place
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JACKSON, Walter (n) MoMM2c V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Martha Jackson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-12-10

8. AGE: Years	Months	Days	If less than one day
35	6	5	hrs. min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Walter Ernest Jackson
13. Birthplace: England

MOTHER
14. Maiden name: Alice Gertrude Hassell
15. Birthplace: England

16. Informant: wife: Mrs. Martha Jackson
Address: 15 Gordon Place, Freeport, N.Y.

17. removal (Burial, cremation, or removal. Which?) Date thereof 8-17-45 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Brooklyn, N.Y.

18. Funeral director: Geo. W. Wise, J.C.T.

Address: 2900 M St., N. W., Wash., D.C.

19. 8-17 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 August 19 45, at 9:27 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 19 45, to 17 Aug 19 45 and that I last saw h. in alive on 17 Aug 19 45

Immediate cause of death: Carcinoma Bronchogenic — DURATION: 1 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: F. S. Ashburn M. D. or other

Address: USNH-NNMC Bethesda Date signed 18 Aug '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ha)

CERTIFICATE OF DEATH

08150

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3½ days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 308 Tennessee Avenue, N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JENKINS, Percy Stanley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Ethel E. Jenkins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 13 April 1889

8. AGE:	Years	Months	Days	If less than one day
	56	4	15	hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: retired navy personnel

11. Industry or business:

FATHER — 12. Name: David A. Jenkins

13. Birthplace: Ohio (deceased)

MOTHER — 14. Maiden name: Martha Orgadine

15. Birthplace: Ohio (deceased)

16. Informant: wife: Mrs. Ethel E. Jenkins

Address: 308 Tennessee Ave., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: August 31, 1945 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers

Address: 517 11th St., S.E., Wash., D.C.

19. 28 Aug. 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 August 1945 at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Aug. 1945, to 28 Aug. 1945 and that I last saw h in alive on 28 Aug. 1945

	DURATION
Immediate cause of death: Coronary Heart Disease, Arteriosclerotic	8 Months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: S. J. GRAY, Lt. (MC) USNR

M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 8-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

4032

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

08151

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No. 4628 Windsor Lane (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs - Rose Jochumsen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Louis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 5, 1875

8. AGE: Years	Months	Days	If less than one day
69	10	6	hrs. min.

9. Birthplace: France (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Pierre Lestelle
13. Birthplace: France
MOTHER 14. Maiden name: Marie Lemberge
15. Birthplace: France
16. Informant: Barry King son-in-law
Address: Same
17. (Burial, cremation, or removal. Which?) Burial Date thereof 8/14/45 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem
Location: Md
18. Funeral director: J. William Lee & Sons
Address: 3004 44th N.E.
19. (Date rec'd by registrar) 8/11 1945 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 11, 1945 at 5 40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/16 1945, to 8/11 1945 and that I last saw h e r alive on 8/11 1945

Immediate cause of death	DURATION
Massive infarction of liver	
Due to: Congenital hemangioma of liver	
Due to:	
Other conditions: Cholecystitis, cholelithiasis, fibrolytic ileus (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.
Autopsy results: Massive infarction of liver, Chronic cholecystitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Bruce T. Benjamin M.D. M. D. or other
Address: Bethesda, Md. Date signed 8/11/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

08152

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: California County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hiram Warren Johnson, Senator

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Minnie Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 2, 1866

8. AGE: Years	Months	Days	If less than one day
78	11	4	hrs. min.

9. Birthplace: California (Town, county, and state)
10. Usual occupation: Government
11. Industry or business

FATHER
12. Name: Grove Johnson
13. Birthplace: New York (deceased)

MOTHER
14. Maiden name: Annie Fredy
15. Birthplace: New York, (deceased)

16. Informant: Wife: Mrs. Minnie Johnson
Address: 122 Maryland Ave., N.W., Washington DC

17. removal (Burial, cremation, or removal. Which?) Date thereof: 8-6-45 (month) (day) (year)
Cemetery or crematory:
Location: California

18. Funeral director: Joseph Gawler Sons Inc.
Address: 1750 Penna. Ave. N.W., Washington, D.C.

19. 8-7-45 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 August 19 45 at 6:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 19 45 to Aug 6 19 45 and that I last saw him alive on Aug 6 19 45

Immediate cause of death: Thrombosis, Cerebral Artery — DURATION: 19 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. P. McCombs, Lt. (MC) USNR
M. D. or other
Address: US N.H., Bethesda, Md. Date signed: 8-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-0

CERTIFICATE OF DEATH

08153

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Monty-

City or town Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs-

Hospital, institution, or street address where death occurred:

#609 Maple Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monty.

City or town Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. #609 Maple Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rhoda Mae Kreimer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Joseph H.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 20, 1876

8. AGE: Years	Months	Days	If less than one day
69		15	hrs. ..... min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Ecker

13. Birthplace Carrol Co. Md.

MOTHER 14. Maiden name Margaret Hannah

15. Birthplace Fredrick Co. Md

16. Informant Etta T. Kerr.

Address Daughter 2420 N. Capitol St

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/45 (month) (day) (year)

Cemetery or crematory Pipe Creek Cem.

Location Carrol County, Md.

18. Funeral director Wm Reuben Dempsey

Address 7557 Wis Ave. Bethesda, Md

19. 8/9 19 45 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 19 45 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 45, to Aug 5 19 45

and that I last saw h.. alive on Aug 4 19 45

	DURATION
Immediate cause of death Coronary Thrombosis	1 Month
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leo J Donovan MD
M. D. or other

Address [illegible] Date signed 8/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47) X

08154

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: D. Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs.

Hospital, institution, or street address where death occurred:
2 Kenilworth Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Monty.

City or town: D. Ch. Ch.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: # 2 Kenilworth Dr.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Milda G. Maddren

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Alfred G.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 31, 1888

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace: Norway
(Town, county, and state)

10. Usual occupation: housewife.

11. Industry or business

FATHER — 12. Name: Olaf Wise Guerdrum

13. Birthplace: Norway

MOTHER — 14. Maiden name: Laura Carlson

15. Birthplace: Norway

16. Informant: Edward Maddren

Address: Same as above

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 8/28/45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cem.

Location: Md.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 8/28 19 45 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 19 1945 to August 22 1945 and that I last saw h alive on August 26 1945

Immediate cause of death: Primary Carcinoma of Lung — DURATION: Probably one year

Due to: Unknown

Due to: —

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Bernard L. French M. D. or other

Address: 1726 M St. N.W. Date signed: 8-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08155

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Fairland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: MONTGOMERY
City or town: FAIRLAND.
(If outside city or town limits, write RURAL und give nearest town)
Street No. R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: HOWARD McC. MARLOW

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	married

6.(b) Name of husband or wife: Katherine Marlow
6.(c) If alive, give age: 83. years

7. Birth date of deceased (mo., day, yr.): Sept 11, 1862.

8. AGE: Years	Months	Days	If less than one day
82	11	8	hrs. min.

9. Birthplace: MARYLAND. (Town, county, and state)
10. Usual occupation: FARMER - retired.
11. Industry or business

FATHER
12. Name: JULIUS MARLOW
13. Birthplace: Md.

MOTHER
14. Maiden name: EVELYN
15. Birthplace: Md.

16. Informant: PEARL MARLOW
Address: FAIRLAND, Md.

17. (Burial, cremation, or removal. Which?) Date thereof: AUG 22, 1945. (month) (day) (year)
Cemetery or crematory: ST MARKS EPISCOPAL CHURCH CEMETERY
Location: FAIRLAND, Md.

18. Funeral director: Arthur Fallon
Address: 254 Carroll St. Takoma Park, D. C.

19. Aug 21 1945 (Date rec'd by registrar) Josephine McHaffie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/19, 19 KS at 1120 G M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/29 KS, 19 to 8/19 19 KS
and that I last saw h[illegible] alive on 8/19 19 KS

Immediate cause of death	DURATION
Carcinoma Prostate	
Due to	
Due to	
Other conditions Chron Myocarditis arter Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W B Lambert M. D. (or other)
Address: Date signed: 8/20 19 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (745)

CERTIFICATE OF DEATH

08156

Reg. Dist. No. 223

1. PLACE OF DEATH

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1514 - 17th St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Dr. James E. Maulding

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia Maulding 6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): January 5, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	1	...hrs. ...min.

9. Birthplace: Bell City, Illinois
(Town, county, and state)

10. Usual occupation: Physician

11. Industry or business: Retired

FATHER
12. Name: James Maulding
13. Birthplace: Illinois

MOTHER
14. Maiden name: Margaret Manchester
15. Birthplace: Ohio

16. Informant: Washington Sanitarium Records
Address: Takoma Park, Md.

17. removal (Burial, cremation, or removal. Which?) Date thereof: Aug 8th '45 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: D.H. Hines Co

Address: 2901 - 14th St. N.W.

19. Aug 6th 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1945, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1945 to August 6 1945, and that I last saw h.i.m. alive on August 6 1945

Immediate cause of death	DURATION
Acute Congestive Cardiac Failure	Terminal
Due to: Coronary Atherosclerosis	7 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert A. Hare M.D. - M. D. or other

Address: Takoma Park, Md. Date signed: 8/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08157

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital Inc.

How long in hospital or institution? 127 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Germantown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Jennie Miles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Mr. Herbert Miles

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 12, 1865

8. AGE: Years	Months	Days	If less than one day
80	6	12	hrs. min.

9. Birthplace: Poplar Springs, Howard Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Andrew Jackson Fluhart

FATHER — 13. Birthplace: Poplar Springs Md.

MOTHER — 14. Maiden name: Sarah Ingles

MOTHER — 15. Birthplace: Poplar Springs, Md

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-27-1945 (month) (day) (year)

Cemetery or crematory: Salem, Cedar Grove

Location: Cedar Grove, Md.

18. Funeral director: Roy M Barber,

Address: Laytonsville, Md.

19. Aug 27 1945 (Date rec'd by registrar) Gertrude B Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1945 at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1945, to August 24 1945 and that I last saw her alive on August 24 1945

Immediate cause of death	DURATION
Uraemia	15 days.
Due to: Senile arteriosclerosis Chronic	?
Due to: Chronic Interstitial Nephritis	?
Other conditions: Fracture Left Hip	3 Yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? Germantown Montg Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Fall, Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md Date signed 8/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

08158

CERTIFICATE OF DEATH

Reg. Dist. No. 21 1

1. PLACE OF DEATH:
County: Montgomery
City or town: near Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: near Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Mt. Airy Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Samuel R. Molesworth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ or wife: Cassie K. Molesworth deceased 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1860

8. AGE: Years: 84 Months: 11 Days: 1 If less than one day: hrs. min.

9. Birthplace: Montgomery Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer (Retired)

11. Industry or business

FATHER
12. Name: Matthew Molesworth
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Ryan
15. Birthplace: Maryland

16. Informant: Mr. James Molesworth
Address: Mt Airy Md

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 8-21-45 (month) (day) (year)
Cemetery or ~~crematory~~: Pine Grove
Location: Mt. Airy Maryland

18. Funeral director: C.M. Waltz
Address: Wenfield Md

19. Aug 20 1945 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19 1945, at 5.45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 23 1938 to Aug 19 1945 and that I last saw h~~im~~ alive on Aug 19 1945

Immediate cause of death	DURATION
Angina Pectoris	yrs
Due to: Chronic Myocarditis	
Due to: and Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C M Dan Poole M. D. ~~or other~~
Address: Mt Airy Md Date signed: 8/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

08159

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Takoma Pk Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Pk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 Hancock ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SARAH JANE NICHOLS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	WIDOWED

6.(b) Name of husband or wife: FREDERICK N. NICHOLS
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 1st 1864

8. AGE: Years: 81 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Newark New Jersey (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER 12. Name: Jacob Vreeland
13. Birthplace: Newark N.J.
MOTHER 14. Maiden name: Sarah Ann Post
15. Birthplace: unknown
16. Informant: Harold W. Nichols
Address: 102 Hancock ave. T.P.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 7 1945 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington D.C.
18. Funeral director: W.W. Chambers Co
Address: 1400 Chapin St N.W.
19. Aug 7 19 45 (Date rec'd by registrar) Josephine D. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~July~~ Aug 7. 19 45 at 2 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24, 19 45 to ~~July~~ Aug 7. 19 45
and that I last saw h~~is~~ alive on ~~July~~ Aug 6. 19 45

Immediate cause of death	DURATION
Congestive Heart Failure	3 days
Due to: Arterio-sclerosis	Indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Bell Jr. M.D. M. D. or other
Address: 6911 5th St. N.W. Washington D.C. Date signed 8/7/45

08160

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E) X

CERTIFICATE OF DEATH

Reg. Diat. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or towe limits, write RURAL and give neorest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn iefaots give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4602 Chevy Chase Blvd.

(If rural, give LOCATION)

2.(a) 11 veteran, oame war

3.(a) FULL NAME Mr. Elof Ohlsson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Siogle, married, widowed, or divorced
Male	Wh-	married

6.(b) Name of husband or wife Mrs. Sigrid Ohlsson

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1866

8. AGE: Years	Months	Days	If less than one day
78	8	25	....hrs. ....min.

9. Birthplace Lands Krona, Sweden

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Olaf Ohlsson

FATHER 13. Birthplace Sweden

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant Washington Sanitarium & Hospital

Address Takoma Park, Maryland

17. Burial Date thereof 8/8/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cem -

Location Maryland

18. Funeral director Wm. R Rumphrey

Address Bethesda Md.

19. Aug 9 1945

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1945, at 12 A.M. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/18 1945, to 8/6 1945 and that I last saw h..i..alive on 8/6 1945

Immediate cause of death	DURATION
Surgical Shock due to anesthesia	
Due to Complete intestinal obstruction	
Due to Annular Carcinoma of descending colon	
Other conditions	

(Iociode pregnancy within 3 mooths of death)

Major findings of operations Complete intestinal obstruction due to Annular Carcinoma of colon Date of op. 8/6 1945

Autopsy results

PHYSICIAN: Please uoderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bruce T. Benjamin, M.D.

M. D. or other

Address Bethesda, Md. Date signed 8/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-L) K

08161

CERTIFICATE OF DEATH ★

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months & 16 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months & 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 571 Woodbine Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: PACKARD, Arthur Mears, AS V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Virginia Packard
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12 February 1917

8. AGE: Years	Months	Days	If less than one day
28	6	9	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business

FATHER
12. Name: Champlain Packard
13. Birthplace: ? (deceased)

MOTHER
14. Maiden name: Mary B. Burk
15. Birthplace: Md.

16. Informant: wife: Mrs. Virginia Packard
Address: 571 Woodbine Ave., Towson, 4 Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-24-45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia
18. Funeral director: Geo. W. Wise, F.C.F.
Address: 2900 M St., N. W., Wash., D.C.

19. Aug. 21 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 Aug. 1945, at 9:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 June 45 1945, to 21 Aug 1945
and that I last saw h im alive on 21 August 1945

Immediate cause of death	DURATION
Sarcoma (Synovial Rt Knee with	>
Due to extensive pulmonary	
metastasis)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: F Ashburn M. D. or other
Address: West Bethesda Md. Date signed: Aug 22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 8/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

08162

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Herbuth Hugh ~~Herbert~~ RHODES, CTC, USN Retired Inactive

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

B.(b) Name of husband or wife: Mrs. Maude Rhodes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2, 1895

8. AGE:	Years	Months	Days	If less than one day
	50	5	14	hrs. min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: Retired ~~Aviation Ordnanceman~~ Ordnanceman

11. Industry or business: U.S. Naval Magazine, Belleau, D.C.

FATHER
12. Name: Edward Rhodes (deceased)
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Susie Egart (deceased)
15. Birthplace: Kentucky

16. Informant: Wife: Mrs. Maude Rhodes
Address: Gambrills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-18-45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: H. W. Chambers S.A.N.

Address: 5801 Cleveland Ave., Riverdale, Md.

19. Aug 16 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 - 16 1945, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 - 11 1945, to 8 - 16 1945 and that I last saw him alive on 8 - 15 1945

Immediate cause of death	DURATION
Cardiac Decompensation	2 yrs.
aortic Stenosis - Mutral Insufficiency	
Due to: Rheumatic Heart Disease	17 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

SIGNATURE: Seymour J. Gray M. D. or other

Address: USNH Bethesda, Md. Date signed: 8-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8/21/45

M

08163

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 1223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2801 Adams Mill Road, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Lyon Robinson
3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Frances H. Robinson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) May 3 - 1865

8. AGE: Years	Months	Days	If less than one day hrs. min.
80	3	16	

9. Birthplace Cleveland, Ohio
(Town, county, and state)
10. Usual occupation Pharmacist
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden name " "
15. Birthplace

16. Informant Mrs. Frances Robinson
Address 2801- Adams Mill Rd. N.W.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Aug 20-1945
(month) (day) (year)
Cemetery or crematory Cemetery, Fort Lincoln
Location Fort Lincoln Bladensburg Md.
18. Funeral director J. William Walters Direct Line
Address 254 Carroll St. Tak Park

19. Aug 20 1945 J. D. Dudley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19th 1945, at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3 - 1945, to August 19 - 1945
and that I last saw him alive on Aug. 17 - 1945

	DURATION
Immediate cause of death Massive Bilateral Pulmonary Infarcts with Emboli	3 da.
Due to Thrombosis Rt. Iliac Vein	7 da.
Due to Right hemiplegia - following recent Cerebral Hemorrhage	3 wk.
Other conditions Diabetis Insipidus.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Massive Bilat. Pulmonary Infarcts with Emboli.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. O. Kotz Jns M. D. or other
Address Wash. San. + Hospital, Takoma Park, Md. Date signed 8/19/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

08164

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda 5
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:
26 Woodhaven Blvd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 Woodhaven Blvd
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Eleanore Rowe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: William D. Rowe

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Sept 29 1904

8. AGE: Years	Months	Days	If less than one day
40	10	9	...hrs. ...min.

9. Birthplace: Manchester N.H.
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: Thomas Chalmers

FATHER 13. Birthplace: Algoma Mich

MOTHER 14. Maiden name: Maude V. Smith

MOTHER 15. Birthplace: Columbus Ohio

16. Informant: William D. Rowe

Address: 26 Woodhaven Blvd.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8/13/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Md

19. 8/13 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7 1945 at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec Med Exam 19... to ...19...

and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death	
Asphyxia by hanging	Few min.
Due to (suicide)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of 8-7-45

Where did injury occur? Bethesda (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brosehart M.D.
M. D. or other

Address: Dept. Med. Exam. Gaithersburg Md Date signed 8-7-45

Mr D Rowe ✓

Hubbard.

900 AM.

Mr 4750. ▽

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

08165

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Seven Locks Rd., Route 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mr. Edgar Edward Sancomb

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna Sancomb
6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) June 6, 1885

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	2	24		

9. Birthplace Malone, New York (Town, county, and state)
10. Usual occupation Owner Gasoline stations
11. Industry or business

FATHER
12. Name Oliver Sancomb
13. Birthplace Malone, N. Y.

MOTHER
14. Maiden name Elizabeth Brodeur
15. Birthplace Canada

16. Informant Wife - Anna Sancomb
Address Seven Locks Rd. RT. 2, Rockville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)
Cemetery or crematory St. Marys Cem -
Location Rockville, Md.

18. Funeral director Wm Reuben Humphrey
Address 2557 Wis. Ave. Bethesda.

19. 8/31/45 (Date rec'd by registrar) Wm E Jones Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1945, at 2:08 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 1945, to Aug 30 1945, and that I last saw h alive on Aug 29 1945

Immediate cause of death	DURATION
Hypertension Heart Disease C.	
Renal Arteriosclerosis	5 years
Due to Heart Failure	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W B Wadsworth M.D. M. D. or other
Address 943 Bonifant St. Silver Spring Date signed 8-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08166

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 910-Silver Spring Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Beatrice M. Shannon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Shannon
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August-18-~~45~~ 1882

8. AGE: Years: 62 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington-D.C.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: James McNally
13. Birthplace: England

MOTHER — 14. Maiden name: Bertha Lichtman
15. Birthplace: ?

16. Informant: Hope Jouvenal
Address: Silver Spring-Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August-11-45 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Forrest Glenn-Md.

18. Funeral director: Deale Funeral Home
Address: 4812-Georgia Ave. Wash. D.C.

19. Aug 8 1945 (Date rec'd by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/8/45 1945 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 20 1945 to Aug. 8 1945 and that I last saw h.. alive on Aug 7 1945

	DURATION
Immediate cause of death: Congestive Heart Failure	2 wks.
Due to: Hypertensive Heart Disease.	5 Yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harold Yeager M.D.
M. D. or other
Address: Mayflower Hotel Wash. D.C. Date signed: 8/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-B

CERTIFICATE OF DEATH

08167

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: GLENMONT (SILVER SPRING)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: BETHESDA
(If outside city or town limits, write RURAL and give nearest town)
Street No.: SUBURBAN HOSPITAL
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Duane DeVorak Stabler

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white.	widowed.

6.(b) Name of husband ~~or wife~~: Montmort O.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov-24-1892.

8. AGE: Years	Months	Days	If less than one day
52	8	17.	hrs. min.

9. Birthplace: Cincinatti. Ohio.
(Town, county, and state)
10. Usual occupation: Registered Nurse.
11. Industry or business: Suburban Hospital.

FATHER
12. Name: MAXMILIAN O DEVORAK
13. Birthplace: CLEVELAND. OHIO

MOTHER
14. Maiden name: LOUISE SMECHENSKY
15. Birthplace: NEW YORK CITY.

16. Informant: Maxmilian O DeVorak.
Address: General Delivery, Miami, Florida

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 15, 1945 (month) (day) (year)
Cemetery or crematory: Friends' Cemetery
Location: Miami, Florida Sandy Spring, Md.

18. Funeral director: Waxnex E. Pumphrey
Address: Silver Spring, Md.

19. Aug 14 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 11 1945, at 10:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19 to 19
and that I last saw h alive on Exam case 19

Immediate cause of death	DURATION
Nembutal poisoning (suicide)	Immediate death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 8-11-45
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Brockett M.D.
Dep. Med. Exam M. D. or other
Address: Gaithersburg Md. Date signed 8-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-E)

CERTIFICATE OF DEATH

68168

Reg. Dist. No. 2/3-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Mont
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Va Ave & Franklin Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Joseph Stevens

3. (b) Social Security Number: 258-03-5955

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	~~widowed~~ Married

6.(b) Name of husband or wife: Pauline Zimmerman Stevens
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): March 3 1890

8. AGE: Years	Months	Days	If less than one day
55	6	25	hrs. min.

9. Birthplace: ~~Canada~~ Kentucky (Town, county, and state)
10. Usual occupation: Stock Room Clerk
11. Industry or business: U.S. Govt.

FATHER
12. Name: not known.
13. Birthplace

MOTHER
14. Maiden name: not known.
15. Birthplace

18. Informant: Dorothy Vane
Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/31/45 (month) (day) (year)
Cemetery or crematory: Rockville Union Cem.
Location: Rockville, Md.
18. Funeral director: Wm Reuben Plumphrey
Address: 7557 Wis. Ave. Bethesda

19. 8/30 (Date rec'd by registrar) 19.. Josephine L. Thelen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 19 45 at 6.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19.. to ... 19..
and that I last saw h.. alive on 7/27 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to	
Due to	
Other conditions Cirrhosis of Liver	5 Years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. W. Walker M. D. or other
Address: Date signed 8/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 37

CERTIFICATE OF DEATH

08169

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ind. County:

City or town: Sullivan
(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 N. Section St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: TAYLOR, Robert Goodwin, CY(T)(AA) USNR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Mildred Elaine Taylor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 20 March 1920

8. AGE: Years	Months	Days	If less than one day
25	5	2	hrs. min.

9. Birthplace: Sullivan, Ind.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: John Spencer Taylor
13. Birthplace: Ind.

MOTHER
14. Maiden name: Irene Kathryn Goodwin
15. Birthplace: Ind.

16. Informant: wife: Mrs. Mildred E. Taylor
Address: 117 N. Section, Sullivan, Ind.

17. removal (Burial, cremation, or removal. Which?) Date thereof 8-22-45 (month) (day) (year)

Cemetery or crematory: Center Ridge

Location: Sullivan, Ind.

18. Funeral director: Geo. W. Wise J.C.F.

Address: 2900 M St., N. W., Wash., D.C.

19. 22 Aug. 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 August 19 45, at 7:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 July 19 45, to 22 Aug. 19 45 and that I last saw him alive on 22 August 19 45

	DURATION
Immediate cause of death: Embolus, pulmonary artery	12 hrs
Due to: Thrombosis, Femoral vein, bilateral	5 days
Due to:	
Other conditions: Poliomyelitis	3 wks

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirmed above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. B. Chew comdr (MC) USNR
W. B. Chew M. D. ~~or other~~

Address: N.N.M.C Bethesda Md. Date signed: 8/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9/24/45

CHANGE OF AGE & BIRTHDAY: Letter filmed 8-27-45 G 97 LL

08170

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Bethesda - Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital Bethesda Md.
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Wm. Fernando Tranbarger.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Mrs. Grace Tranbarger.
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): Sept. 23-1876.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	10	19	25	

9. Birthplace: Indiana (Town, county, and state)
10. Usual occupation: Lawyer
11. Industry or business
FATHER 12. Name: Wm. Alfred Tranbarger.
13. Birthplace: Indiana.
MOTHER 14. Maiden name: Elizabeth J. Trent
15. Birthplace: Indiana
16. Informant: Mrs. Grace Tranbarger
Address: 908 - N. Kansas St. Arlington
17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 13 1945 (month) (day) (year)
Cemetery or crematory: Arlington, Va.
Location
18. Funeral director: Boyd Lee Early
Address: Arlington, Va.
19. 8/13 1945 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1945 at 5:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945, to Aug 12 1945
and that I last saw him alive on Aug 12 1945
Immediate cause of death: Cerebral apoplexy

	DURATION
Due to: Arteriosclerosis and cardiac incompetence	many years 2 wks.
Due to: Chronic nephritis.	many years.
Other conditions: Previous Lumi Pleurisy	March 1945

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Edward H. Nicolet M.D.
M.D. or other
Address: 1726 Eye St. N. W. Washington D.C. Date signed 8/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08171

★ Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery Co.
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
How loog in above placo of death? 1 hr. 10 m.
Hospital, Institution, or street address whore death occurrod: Suburban Hosp't.
How long in hospital or Institiution? 1 hr. 10 m.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Lindon
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy Warfield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife
8.(c) If alivo, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Newborn	—	—	2 hrs. 10 min.

9. Birthplace Lindon, Md. (Town, county, and state)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name John Rollins
13. Birthplace Maryland

MOTHER
14. Maiden name Ida Mae Warfield
15. Birthplace Maryland

16. Informant Father
Address Lindon, Md.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemotery or crematory
Location Suburban Hosp't.

18. Funeral director
Address

19. 8/22/45 Wm E Johns Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 19 45 at 240 ☐ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 19 45 to Aug 19 19 45 and that I last saw him alive on Aug 19 19

Immediate cause of death	DURATION
Prematurity	2 hrs. 10 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C W Mitchell M D
M. D. or other
Address Silver Spring, Md. Date signed 8-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08172

CERTIFICATE OF DEATH

★ Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Monty
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 hrs. 40 mins.
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 11 hrs. 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Gaithersburg
(If ontside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Warfield

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	Col.	~~Single~~ Widower

6.(b) Name of husband or wife: Martha warfield.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4 1863

8. AGE:	Years	Months	Days	If less than one day
	82	1	8	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Albert Warfield.
13. Birthplace: md.

MOTHER
14. Maiden name: Kate Chase
15. Birthplace: md.

16. Informant: Jacob Ashton
Address: Gaithersburg md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/45 (month) (day) (year)
Cemetery or crematory: Emory Grove Cemetery
Location: Nr. Gaithersburg md
18. Funeral director: Ernest C. Tschiffely
Address: Gaithersburg md
19. Aug 13 1945 (Date rec'd by registrar) Alinda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12 1945 at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1944 to 1945
and that I last saw h alive on 1945

Immediate cause of death	DURATION
Shock - Internal hemorrhage	12 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of 8-11-45
Where did injury occur? Gaithersburg (City or town) Monty (County) Md (State)
Injured at home, farm, Industry, public place (where?): highway
Means of injury: Hit + run auto Injured at work? no

23. SIGNATURE: Frank J. Broccard M.D.
Dep. Med. Exam. M. D., or other
Address: Gaithersburg md Date signed 8-12-45

08173

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? two years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ____ County ____
City or town ____
(If outside city or town limits, write RURAL and give nearest town)
Street No. ____
(If rural, give LOCATION)
2.(a) If veteran, name war ____

3.(a) FULL NAME James Buchannan Welsh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife Melissa Elder
6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 9/17/1881

8. AGE: Years	Months	Days	If less than one day
63	11	3	____ hrs. ____ min.

8. Birthplace Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business —
FATHER 12. Name Edward F. Welsh
13. Birthplace Va
MOTHER 14. Maiden name Ida Roberts
15. Birthplace Md
16. Informant Mrs. J. B. Welsh
Address Derwood Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/17/45 (month) (day) (year)
Cemetery or crematory Rockville
Location ____
18. Funeral director Wm. R. Pumphrey
Address Rockville Md
19. Aug 15, 1945 (Date rec'd by registrar) Gertrude B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14/ 1945 at 4 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/11/ 1945, to 8/14/ 1945
and that I last saw him alive on 8/5/ 1945

	DURATION
Immediate cause of death Coronary Occlusion	1
Due to Chronic Myocarditis and Hypertension	4 yrs
Due to ____	
Other conditions ____	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ____
Means of injury ____ Injured at work? ____

23. SIGNATURE [signature] M. D. or other
Address Sandy Spring Md Date signed Sept 10 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

08174

CERTIFICATE OF DEATH

★ Reg. Dist. No. 214

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

VS A15

1. PLACE OF DEATH:

County Monty

City or town Linden - Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: —

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monty

City or town Linden - Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Prencel Eugene Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11 1945

8. AGE: Years — Months 1 Days 12 If less than one day ..... hrs. ..... min.

9. Birthplace Wash. DC. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name John Young

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Eulia Williams

15. Birthplace Wash. DC.

16. Informant Eulia Williams

Address Linden - Silver Spring md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24, 1945 (month) (day) (year)

Cemetery or crematory Mt. Zion Cemetery

Location Silver Spring, Md.

16. Funeral director Robert L. Trouvedel

Address Rockville, Maryland

19. Aug 24 1945 (Date rec'd by registrar) Josephine D. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1945, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 22 1945 to Aug. 23 1945

and that I (last saw him) alive on ..... 19....

	DURATION
Immediate cause of death	
Asphyxia	Dumb died in crib
Due to Suffocation (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 8-23-45

Where did injury occur? Silver Spring (City or town) Monty (County) md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Injured at work?

23. SIGNATURE Frank J. Brashear M. D. or other

Address Gaithersburg md Date signed 8-23-45


RECEIVED
AUG 27 1945
BUREAU P. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

08175

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
SLIGO CREEK PARKWAY - (IN AUTO)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8512 CEDAR STREET
(If rural, give LOCATION)
2.(a) If veteran, name war: WORLD #1

3. (a) FULL NAME: PHILLIP M WILLIAMSON

3. (b) Social Security Number: 214-03-8747

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JAN - 10 - 1897

8. AGE: Years	Months	Days	If less than one day
48	7	13	hrs. min.

9. Birthplace: ALABAMA
(Town, county, and state)
10. Usual occupation: ASST CHIEF - TEXTILES & CLEANING DIV.
11. Industry or business: WAR PRODUCTION BOARD
FATHER 12. Name: GEORGE WILLIAMSON
13. Birthplace: ENGLAND
MOTHER 14. Maiden name: LILLIE ROSE McKENZIE
15. Birthplace: SCOTLAND
16. Informant: LT. ALFRED M. GILL (NEPHEW)
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: AUG - 27 - 1945 (month) (day) (year)
Cemetery or crematory: ARLINGTON NATIONAL
Location: ARLINGTON Co. VA
18. Funeral director: Warner & Pumphrey
Address: 8434 - Ga Ave. Silver Spring. Md.
19. Aug 29 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 19 45 at 8:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
(a)	sudden
Due to: (b) Coronary occlusion	unknown
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bronhard M.D. Dep. Med. Exam. M. D. or other
Address: Washington D.C. Date signed: 8-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08176

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: Suburban Hospital
How long in hospital or institution? 20 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Monty.
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4613 Darling La.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Louise Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Elmer E.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1865

8. AGE: Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace: Nebraska (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER — 12. Name: John Dorner
FATHER — 13. Birthplace: Germany
MOTHER — 14. Maiden name: Catherine Mueller
MOTHER — 15. Birthplace: Germany
16. Informant: Cleona Lesher
Address: 4613 Darling La. Bethesda
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 8/15/45 (month) (day) (year)
Cemetery or crematory: Danville Ill.
Location: Danville, Ill
18. Funeral director: Wm Reuben Plumphrey
Address: 2557 Wis. Ave. Bethesda
19. Aug 15 1945 Wm E Jobert Md. E
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1945, at 11 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1945 to Aug 14 1945 and that I last saw her alive on Aug 13 1945

Immediate cause of death	DURATION
Hypostatic Congestion	7 days
Lung	
Due to Erysipelas of Face -	
An infection she had received	2 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lee L Emmons M. D. or other
Address: 8016 Georgia Ave. Date signed 8/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

08177

CERTIFICATE OF DEATH

Reg. Dist. No. 716

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 15 - Winston Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary I. Wynkoop

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John F. Wynkoop
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 14th. 1878

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: William Havenner
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Mary McGurr
15. Birthplace: Washington, D. C.

16. Informant: JohnF. Wynkoop
Address: 15 - Winston Drive, Beth. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 7-1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington, D. C.

19. Funeral director: Thomas F. Murray
Address: 2007- Nichols Ave. S. E.

19. 8/6 1945 Wm E Jules
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 4 1945 at 4.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1939, to Aug 4 1945
and that I last saw h.. alive on Mar 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Arteriosclerosis	
Due to: Hypertension	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Russell Coombs Coyne M. D. or other
Address: 1801 - Eye St. Date signed: 8-4-1945